Dr. David R. Winchester, D.M.D., P.C.
Request Amendment of Healthcare Information

This form is to request that an amendment be made to the protected healthcare information you maintain for patient:

_____

The requested amendment(s) and the reasons for them are as follows:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

If more space is needed, please, attach pages as needed.

I have read your Notice of Privacy Policies and I understand that you are not required to honor this request.

Signature _____ Date _____
If this form is signed by a personal representative of the patient, please, complete the following:

Personal Representative's Name _____

Relationship to Patient _____

Mail or deliver the completed form to:

Dr. David R. Winchester
Suite 100
2500 Center Point Parkway
Center Point, AL 35215